

**DEPARTMENT OF SOCIAL SERVICES  
DISABILITY DETERMINATION SERVICE**

**SERVICES BILL** DISABILITY DETERMINATIONS  
1500 SOUTHRIDGE DR STE 100  
JEFFERSON CITY, MO 65109  
573/751-2929

DDS OFFICE S80
CONTRACT 5935771
DATE OF ISSUE 8/09/19

TO: <b>MIDWEST CES</b> ATTN: DAVID FRANSEN 9218 METCALF AVE SUITE 211 OVERLAND PARK, KS 66212	RE: GARY MURRILL APT H 201 N WITHERS LIBERTY, MO 64068 Phone: 816-642-1693 SSN: 416-02-4105 DOB: 3/12/1972
REMIT TO: <b>MIDWEST CES</b> 12 W 3100 S BOUNTIFUL, UT 84010	Remit Vendor Number: 0265184 Remit Phone number: 866/612-7449 Remit Fax Number: 801/294-5304 Service Vendor Phone 866/612-7449 Service Vendor Fax 866/373-8614
NOTE: To ensure payment of this invoice, the following remittance vendor information must be provided. (*)	
Analyst Phone # : 573/751-0673	

*CALIFORNIA RESIDENCY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	*FEDERAL TAX ID NUMBER F 453248765	*TYPE OF BUSINESS <input checked="" type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> INDIVIDUAL PROPRIETOR
This invoice is void if not signed and submitted within 90 days from Date of Examination (or 90 days from Date of Issue for Evidence of Record) I authorize release of this report in accordance with the provisions of the Federal Privacy Act of 1974 (P.L. 93-579). Services performed under this authorization have been provided in accordance with the Civil Rights Act of 1964 (P.L. 88-382). PAYMENT FOR THE FOLLOWING SERVICES WILL NOT BE BILLED TO NOR ACCEPTED FROM ANY SOURCE OTHER THAN THE AUTHORIZING AGENCY.		

YOU ARE HEREBY AUTHORIZED TO PROVIDE THE LISTED SERVICES TO THE ABOVE INDIVIDUAL  
ON 9/14/19 AT 12:30 PM

AUTHORIZATION		INVOICE	
SERVICE NUMBER	DESCRIPTION OF SERVICE	AMOUNT AUTH.	BILLED AMOUNT
190623	Internist Examination and Report (physical examination)	185.96	
5935772			
Total		185.96	185.96

PLEASE NOTE:

**EXHIBIT A**

ANALYST NAME SARAH	I hereby certify under penalty of perjury that the information provided on this document is true and correct.		
AUTHORIZING SIGNATURE	VENDOR SIGNATURE/TITLE <i>Kylee Bawden</i>	DATE 9/20/2019	
CASE NUMBER 1350867	DDS VENDOR NUMBER 0304308	DATE 06/03/21	

**Midwest CES, LLC**  
**1-866-612-7449**

Medical Report  
September 14, 2019

RE: Gary Murrill  
SSN: 416-62-4106  
Case #: 1350867  
Contract #: 5935771

North Kansas City, Missouri

Mr. Murrill is a 47-year-old male who alleges disability due to arthritis. He was positively identified by photo ID, came with his spouse and seems to be a reliable historian.

**HISTORY OF PRESENT ILLNESS:**

Arthritis: The claimant reports a history of arthritis starting in 2014 affecting his hips and hand. He had hip surgery in 2014. He attended physical therapy in 2014. His current symptoms include pain stiffness, decreased mobility, and swelling. He describes constant achy, sometimes sharp, burning pain in his hips and hand. He states pain intensity at the time of the examination of 4/10, which is typical. Medication relieves his symptoms while activity and weather change make them worse. The claimant reports this affects his ability to work secondary to decreased mobility.

**PAST MEDICAL HISTORY:**

2013- Hepatitis C  
1985- bottle rocket in the right eye

**PAST SURGICAL HISTORY:**

2015- hip replacement  
2014- left hip replacement

**MEDICATIONS:**

None listed

**ALLERGIES TO MEDICATIONS:**

NKDA

**SOCIAL HISTORY:**

The claimant is an unemployed male who has been out of work since 2018 when he worked as a temporary warehouse employee. He is separated and doesn't have children. He has smoked 1 pack a day for 10 years and denies the use of alcohol and recreational drugs. His typical daily activity consists of watching TV and sleeping.

**FAMILY HISTORY:**

Mother- spinal stenosis

**REVIEW OF SYSTEMS:**

The claimant reports he is positive for weight loss, night sweats, dyspnea on exertion, leg pains when walking, paresthesias, poor muscular coordination, emotional problems, headaches, vision changes, shortness of breath, muscle pain, joint swelling, limitation of motion, muscular weakness, cramps, vomiting, and diarrhea.

**FUNCTIONAL LIMITATIONS:**

The claimant reports functional limitations, secondary to pain, as sitting 60 minutes, standing 60 minutes, walking 1 block and lifting and carrying 20 pounds repetitively and 25 pounds occasionally. The claimant also reports limitations to vision.

**PHYSICAL EXAM:****VITAL SIGNS:**

BP- 172-118

HR- 104

**HEIGHT** (without shoes) 5 feet, 9 inches

**WEIGHT** (without shoes) 173 pounds

**GENERAL APPEARANCE:** A 47-year-old male who appears his stated age and is in no acute distress.

**HEENT:** Normocephalic atraumatic. No scleral icterus or conjunctival petechiae. The funduscopic examination was normal. No oropharyngeal erythema, exudate or other lesion. External auditory canals were normal in appearance. No lesions in the nares. Pupils were equally round and reactive to light. Extraocular movements were intact. Visual acuity was 20/13-1 left eye, 20/30 right eye and 20/13-1 bilaterally without corrective lenses with intact visual fields by confrontation.

**NECK:** There is no thyromegaly, thyroid nodule, lymphadenopathy or mass appreciated.

**CARDIOVASCULAR:** Jugular venous pulsations are normal above the sternal border. There was a regular rate and rhythm without murmurs, rubs or gallop. (See chart below)

	L / R		L / R
<b>Carotid :</b>	2+/2+	<b>Radial</b>	2+/2+
<b>Dorsalis Pedis</b>	2+/2+	<b>Posterior Tibialis</b>	2+/2+

**LUNGS:** The lungs were clear to auscultation and percussion bilaterally.

**ABDOMEN:** Soft, non-tender, non-distended with normally active bowel sounds. No organomegaly, hepatomegaly or mass appreciated.

**EXTREMITIES:** There was no clubbing, cyanosis or edema.



**SKIN:** No lesions appreciated.

**NEUROLOGIC:**

**GENERAL:** The claimant was alert and had good eye contact. The claimant had fluent speech. The claimant could hear normal conversational speech. The claimant's mood was appropriate and the claimant had clear thought processes. The claimant's memory was normal and concentration was good. The claimant was oriented to time, place, person and situation.

**CRANIAL NERVES:** Cranial nerves II-XII were grossly intact.

**CEREBELLAR:** The claimant had a slow, antalgic gait. The claimant did not present with an assistive device. Hand-eye coordination was good. Romberg test was negative.

**MUSCLES:** The claimant had no palpable muscle spasms. Muscle bulk and tone are within normal limits. Muscle strength is shown on the range of motion forms attached.

**NERVES:** Sensory examination was normal to light touch throughout. The claimant's straight leg test is noted on the range of motion forms attached.

**REFLEXES:** See details on reflex chart below.

Reflexes	L	R	Reflexes	L	R
Patellar	2+	2+	Brachioradialis	2+	2+
Ankle (Achilles)	2+	2+	Biceps	2+	2+

**MUSCULOSKELETAL:**

There was no joint swelling, erythema, effusion, or deformity. The claimant has left spine tenderness. The claimant's hands and fingers appeared normal. I generally observed the claimant to be able to button and unbutton a shirt, pick up and grasp a pen and write a sentence and lift, carry and handle personal belongings with moderate difficulty. The claimant was able to squat and rise from that position with difficulty. The claimant was able to rise from a sitting position without assistance and had difficulty getting up and down from the exam table. The claimant was able to walk on heels and toes with difficulty. Tandem walking was normal and the claimant could stand but not hop on one foot bilaterally. The claimant could dress and undress adequately well and was cooperative with exam maneuvers. The claimant's effort is noted on range of motion forms.

**RANGE OF MOTION:**

Please see attached range of motion pages.

**IMPRESSION:**

On his exam today, he has surgical scar to support left-sided hip replacement. He has a mild antalgic gait. He has a moderate amount of weakness to the left lower extremity that is noted 4/5 in strength, 5/5 in the other extremity. Normal range of motion. Strength testing was limited towards just the left lower extremity, but really no other strength or

Gary Murrill

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range of motion testing were noted on this exam today. He unfortunately does not have any medical records. He did have some L-spine tenderness on my exam.

**DIAGNOSIS:**

1. Alleged spinal stenosis. No medical records.
2. Left-sided hip replacement with mild antalgic pain with ambulation.
3. Hepatitis C alleged. No medical records.

A handwritten signature in dark ink, appearing to read "Jesal Amin", is written over a horizontal line. Below the line, the words "PHYSICIAN'S SIGNATURE" are printed in a small, bold, sans-serif font.

Jesal Amin, M.D.

License#: 2018031830

Expiration: 01/31/2020



MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION  
VOCATIONAL REHABILITATION  
RANGE OF MOTION VALUES

GIVE ACTIVE, AND IF NEEDED, PASSIVE RANGES

PATIENT NAME

Gary Merrill

DATE OF BIRTH

EVALUATION DATE

**SHOULDER**

A. FLEXION (0° - 180°)

RIGHT N LEFT N



B. ABDUCTION (0° - 180°)

RIGHT N LEFT N



C. ADDUCTION (0° - 30°)

RIGHT N LEFT N

D. INTERNAL ROTATION (0° - 90°)

RIGHT N LEFT N

E. EXTERNAL ROTATION (0° - 90°)

RIGHT N LEFT N

**ELBOW**

A. FLEXION-EXTENSION (0° - 150°)

RIGHT N LEFT N



B. SUPINATION (0° - 80°)

RIGHT N LEFT N



C. PRONATION (0° - 80°)

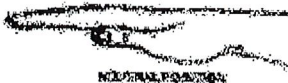
RIGHT N LEFT N



**WRIST**

A. DORSIFLEXION (0° - 50°)

RIGHT N LEFT N



B. PALMAR FLEXION (0° - 90°)

RIGHT N LEFT N

C. RADIAL DEVIATION (0° - 20°)

RIGHT N LEFT N

D. ULNAR DEVIATION (0° - 30°)

RIGHT N LEFT N

**KNEE**

A. FLEXION-EXTENSION (0° - 150°)

RIGHT N LEFT N



CAN THE HAND BE FULLY EXTENDED?

CAN A FIST BE MADE?

CAN THE FINGERS BE OPPOSED?

**GRIP STRENGTH**

RIGHT: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☒ 5

LEFT: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☒ 5

**UPPER EXTREMITY STRENGTH (5 = NORMAL)**

EFFORT

☒ GOOD ☐ FAIR ☐ POOR

RIGHT: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☒ 5

LEFT: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☒ 5

(SEE REVERSE SIDE)



**GIVE PASSIVE RANGES**

PATIENT NAME

Gary Murrell

DATE OF BIRTH

EVALUATION DATE

**HIP**

A. FORWARD FLEXION (0° - 100°)

RIGHT N LEFT N

B. BACKWARD EXTENSION (0° - 30°)

RIGHT N LEFT N

C. ABDUCTION (0° - 40°)

RIGHT N LEFT N

D. ADDUCTION (0° - 20°)

RIGHT N LEFT N**ANKLE**

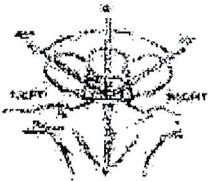
A. DORSI-FLEXION (0° - 20°)

RIGHT N LEFT N

B. PLANTAR-FLEXION (0° - 40°)

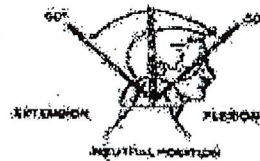
RIGHT N LEFT N**CERVICAL SPINE**

A. LATERAL FLEXION (0° - 45°)

RIGHT N LEFT N

B. FLEXION (0° - 50°)

C. EXTENSION (0° - 60°)



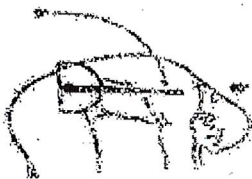
D. ROTATION (0° - 60°)

RIGHT N LEFT N**LUMBAR SPINE**

A. FLEXION-EXTENSION (0° - 90°)

60

B. LATERAL FLEXION (0° - 25°)

RIGHT N LEFT N**STRAIGHT LEG RAISING (0° - 90°) (IF POSITIVE, PLEASE EXPLAIN IN YOUR NARRATIVE REPORT)**

SUPINE RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

SEATED RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

**LOWER EXTREMITY MUSCLE WEAKNESS:**

RIGHT

LEFT

☐ 1☐ 2☐ 3☐ 1☐ 2☐ 3

(5 = NORMAL, INDICATE ABNORMAL EXTREMITY OR MUSCLE AREA)

EFFORT

☒ GOOD☐ FAIR☐ POOR

Note: Your narrative report should include a discussion of sensory and/or reflex abnormalities including the extent of any loss. The testing method should be recorded. Please describe the ability to heel and toe walk, squat, get on and off the examining table, and gait and station. Describe the reason for any use of assistive devices.

PHYSICIAN'S SIGNATURE

A0100-1079 (2-08)

SOURCE: GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, FIFTH ED., 1986